Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dr. Pedro Nosnik 4100 W. 15th Street, Ste 206 Plano, TX 75093	MFDR Tracking #: M4-05-7980-01 DW Injured Dat
Respondent Name and Box #: Fidelity & Guaranty Insurance Rep. Box #: 19	Empl Insuranc

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUME

Requestor's Position Summary: "Fee Issue carrier has not paid at correct fee schedule"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $19.40
3. CMS 1500s
4. EOBs

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TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
12/14/04	99213	F	1, 4, 6	$6.26
01/04/05	99213	F	1, 5, 6	$6.33
02/01/05	99213	45	2, 3, 5, 6	$6.33
Total Due;				$18.92

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

[redacted]

1. These services were partially reimbursed by the Respondent with reason code "F - Fee Schedule MAR Reduction".
2. These services were partially reimbursed by the Respondent with reason code "45 – Charges Exceed Your Contracted Legislated Fee Arrangement."
3. In regards to the "45" payment code on there is no contractual or PPO fee arrangement with this provider. Contract verification attempts were made to Frank Gates Services Co, bill reviewers for Fidelity & Guaranty and to Flahive, Ogden, & Latson with no response. Requestor has provided a statement verifying that "Dr. Pedro Nosnik does not find we have any contract with any company to take a PPO reduction for workers comp. claims."
4. CPT code 99213 for DOS 12/14/04 has a MAR of $68.24 based on $54.59 x 125%. Respondent has paid an amount of $61.98 and Requestor is due the additional amount of $6.26 per Rule 134.202(b).
5. CPT code 99213 for DOS 01/04/05 and 02/01/05 has a MAR of $68.31 based on $54.65 x 125%. Respondent has paid an amount of $61.98 and Requestor is due the additional amount of $6.33 for each of these DOS per Rule 134.202(b).
6. Per review of Box 32 on CMS-1500, zip code 75220 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

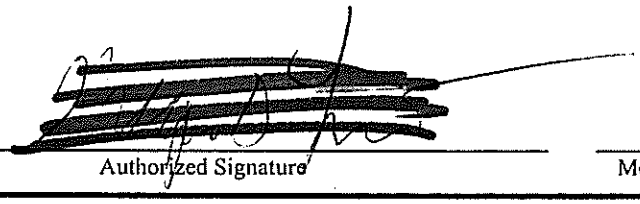
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $18.92 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:



Authorized Signature	Medical Fee Dispute Resolution Officer	01/08/08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.